FRAMEWORK FOR STATE EVALUATION OF CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

(Developed by States, for States to meet requirements under Section 2108(b) of the Social Security Act)

State/Territory: Maine

The following State Evaluation is submitted in compliance with Title XXI of the Social Security Act (Section 2108(b)).

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(Signature of Agency Head)

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Reporting Period: FFY 98 & FFY 99

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SECTION 1. SUMMARY OF KEY ACCOMPLISHMENTS OF YOUR CHIP PROGRAM

This section is designed to highlight the key accomplishments of your CHIP program to date toward increasing the number of children with creditable health coverage (Section 2108(b)(1)(A)). This section also identifies strategic objectives, performance goals, and performance measures for the CHIP program(s), as well as progress and barriers toward meeting those goals. More detailed analysis of program effectiveness in reducing the number of uninsured low-income children is given in sections that follow.

1.1 What is the estimated baseline number of uncovered low-income children?

The preliminary 1999 estimated baseline for uncovered low-income children in Maine potentially eligible for CHIP is 7,835; this number represents children from households with income between 125% and 200% FPL, as shown in the table below. (Please refer to 1.1.1 and 1.1.2 regarding limitations of this preliminary estimate).

Is this estimated baseline the same number submitted to HCFA in the 1998 annual report? If not, what estimate did you submit, and why is it different?

No, the estimated baseline number of potential CHIP enrollees submitted to HCFA in 1998 (based on 1997 household survey data) was 11,357 which was comprised of 3,046 children from households between 125% and 133% FPL and 8,311 children from households between 134% and 185% FPL.

Please note that Maine's income limit for CHIP increased from 185% to 200% FPL in October 1999. To compare the 1999 estimated baseline number of uncovered low-income children potentially eligible for CHIP with that submitted to HCFA in 1998, the 125% to 185% income range of FPL households should be used. The 1999 preliminary estimate for this income range is 7,158, a reduction of 4,199 from the 1998 estimate of 11,357 uninsured children in this category.

The 1999 preliminary estimates of uninsured children compared to 1997 estimates are shown in the following table:

FPL Income Category	Number of Uninsured Children in 1997	Number of Uninsured Children in 1999
< 125%	7,658	6,000
125% - 185%	11,357	7,158
186% - 200%	2,338	677
>200%	6,557	7,796
No Income Information	4,071	4,062
Total	31,981	25,693

1.1.1 What are the data sources and methodology used to make this estimate?

1997 Random Household Survey

The State of Maine sponsored a random household survey in 1997 to determine the number of uninsured children and insured children in low-income families. The purpose of the survey was to gauge the incidence of uninsurance for children in the State in order to plan for the implementation of the CHIP program. A survey instrument was developed by Mathematica Policy Research, Inc.; data were collected in October and November 1997 and the analysis, conducted by the Muskie School of Public Service, was completed in January 1998.

The sampling framework was selected to ensure that adequate numbers of urban and rural residents would be interviewed. A total of 13,291 households were included in the study sample. Trained telephone interviewers used screening questions to identify households with children and interviews were conducted with 2,449 respondents in households with children. This number included a subsample of 459 low-income households with privately-insured children and 214 households with uninsured children. The remaining 1,776 households with children were above 250% FPL. Detailed information on child health status, use of health services, income, employment, and health insurance benefits was collected.

A comprehensive call schedule was used to maximize the likelihood of reaching household members; these efforts resulted in a 75% response rate among eligible households (families with children). The results of this survey were used for the baseline estimation submitted to HCFA in 1998.

1999 Random Household Survey

A new random household survey, intended to replicate the 1997 survey, was sponsored by the State of Maine in 1999. The new survey used the same survey methodology, instrument, and weighting methodology; however, a smaller sampling frame was used due to cost constraints. A survey firm was engaged to collect the data and administer the survey; data collection began in December 1999. A sample of 8,141 was used with the expectation of obtaining 100 interviews with households with uninsured children and 300 interviews with low-income households with privately insured children.

Survey interviews with low-income households with privately insured children have been completed; however, as of March 1, 2000, 2/3 of the 100 households with uninsured children have been completed. Data for this group continue to be collected and completion is expected shortly. Therefore, the 1999 survey results reported herein are *preliminary* and expected to be adjusted after the survey administration and final analyses have been completed.

The preliminary survey results on the partially completed survey have been weighted, using the same weighting methodology used in 1997. When the survey has been completed confidence intervals will be re-calculated; as expected for a partially completed survey, the current confidence intervals are large. After the survey has been completed and the final data collected and analyzed, and new confidence intervals are calculated, a final report will be published and provided to HCFA.

1.1.2 What is the State's assessment of the reliability of the baseline estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence interval if available.)

As discussed in item 1.1.1, the survey estimate is *preliminary* and thus, the State is reserving its assessment until data collection is finished and final analyses are completed. The baseline estimated number of uninsured low-income children will be finalized upon completion of the survey which is still in the field.

The 1999 survey methodology was intended to replicate the 1997 survey for comparability purposes (see discussion in item 1.1.1). The only variation was the use of a smaller sample size due to cost constraints. After the full 100 households are completed, survey results will be considered sufficient to calculate statewide estimates. The preliminary estimate based on partial completion of 68 households indicates that there are 25,693 uninsured children in the state (please refer to table in 1.1). The 95% confidence interval range around this estimate is 21,067 to 30,319.

1.2 How much progress has been made in increasing the number of children with creditable health coverage (for example, changes in uninsured rates, Title XXI enrollment levels, estimates of children enrolled in Medicaid as a result of Title XXI outreach, anti-crowd-out efforts)?

The random household survey is the primary source of information available to estimate the progress made in decreasing the number of uninsured children in the State. In 1998 Maine reported that there were 11,357 uninsured children within the guidelines (125% - 185% FPL) for Medicaid Expansion and Cub Care. The preliminary estimate of uninsured children for 1999 for this income range is 7,158. (Please refer to limitations discussion in item 1.1.1) While the health care environment has changed (see 2.2.3) and the CHIP has been operational only for a relatively short period, these preliminary numbers would suggest that the Maine CHIP program is having a positive impact on increasing the number of low-income children in the State with creditable health coverage.

How many more children have creditable coverage following the implementation of Title XXI? (Section 2108(b)(1)(A))

For the period of July 1998 – September 1999, the total unduplicated number of children ever enrolled in CHIP was 13,910.

1.2.1 What are the data sources and methodology used to make this estimate?

The data source and methodology for the random household survey estimate is discussed in item 1.1.1.

The data source for the number of CHIP enrollees is the Bureau of Medical Services, Maine Medicaid Decision Support System.

1.2.2 What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Provide a numerical range or confidence intervals if available).

The random household survey estimate is preliminary and thus, the State is reserving its assessment until data collection is finished and final analyses are completed. (Please refer to limitations discussion in item 1.1.1.)

1.3 What progress has been made to achieve the State's strategic objectives and performance goals for its CHIP program(s)?

Please complete Table 1.3 to summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in the Title XXI State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List the State's strategic objectives for the CHIP program, as specified in the State Plan.

Column 2: List the performance goals for each strategic objective.

Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

For each performance goal specified in Table 1.3, please provide additional narrative discussing how actual performance to date compares against performance goals. Please be as specific as possible concerning your findings to date. If performance goals have not been met, indicate the barriers or constraints. The narrative also should discuss future performance measurement activities, including a projection of when additional data are likely to be available.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
Increase the number of children in Maine with health insurance by expanding Medicaid eligibility and creating Cub Care, a new health insurance program	Decrease rate of uninsurance	Data Sources: 1997 & 1999 Muskie School of Public Service random household surveys. Progress Summary: Preliminary data suggests that Maine CHIP is having a positive impact on increasing the number of low-income children with creditable health coverage. See 1.2.
OBJECTIVES RELATED TO CHIP ENROLLMENT		
Increase the number of children in Maine with health insurance by expanding Medicaid eligibility and creating Cub Care, a new health insurance program	Enroll 3,911 children in Cub Care by 9/30/99	Data Sources: Bureau of Medical Services, Maine Medicaid Decision Support System Progress Summary: The total unduplicated number of children ever enrolled in Cub Care for FFY 98 & 99 was 3,809.

Table 1.3		
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
Increase the number of children in Maine with health insurance by expanding Medicaid eligibility and creating Cub Care, a new health insurance program	Increase Medicaid participation by enrolling 6,541 children in the Medicaid Expansion program	Data Sources: Bureau of Medical Services, Maine Medicaid Decision Support System Progress Summary: For FFY 98 & 99, the total unduplicated number of children ever enrolled in Medicaid Expansion was 10,101.
OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		
Provide access to a consistent source of health care that will meet the needs of enrolled children	Enroll children in health plans; match children with PCPs & increase regular source of health care; decrease ER use	Data Sources: Bureau of Medical Services, Maine Enrollment and Capitation System and Maine Medicaid Decision Support System Progress Summary: As of 9/30/99, the estimated number of CHIP children enrolled in a MCO was 577. As explained below in the narrative detail, Maine did not enroll as many children in MCOs as originally envisioned when CHIP was implemented. The percentage of CHIP participants with 11+ months of eligibility during FFY 99 who had one or more visits with a PCP ranged between 77% - 97% depending on age. See Attachment 5. See Attachment 6 regarding ER visits and admissions for avoidable hospital conditions for CHIP participants Narrative Detail: At the time CHIP was implemented, the Department of Human Services expected to move forward with enrolling CHIP participants in MCOs. The Department issued 2 Requests for Proposals seeking MCOs interested in providing

Table 1.3		
		services to the Medicaid/CHIP population but ultimately the Department was able to contract with only 1 MCO. The MCO currently operates in 7 counties. Participants enroll on a voluntary basis. The Department expects to transition to mandatory enrollment within the next 12 –18 months. The Department did move forward with its PCCM initiative. PCCM is operational in 9 counties and should be operational statewide by December 2000. As of 9/30/99, 2,026 CHIP children were enrolled in PCCM. All of the children enrolled in either the MCO or PCCM have a medical home.
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
Improve quality outcomes for children as measured by key indicators	Increase early childhood and adolescent immunization rates; increase EPSDT follow-up	Data Sources: Bureau of Medical Services, Maine Medicaid Decision Support System Progress Summary: See Attachment 7 regarding recipients who turned 2 years of age and received immunizations. See Attachment 8 regarding well child visits for children who turned 15 months, for children ages 3 –6, and for children ages 12+
OTHER OBJECTIVES		
Provide quality health care to enrolled children that meets their needs and expectations	Enrollee satisfaction; decrease complaints/grievances	Data Sources: *Enrollee satisfaction* – Two CHIP enrollee surveys conducted in 1999 by Muskie School of Public Service. Six focus groups conducted by the Department of Human Services in 1999/2000. *Complaints/grievances* – PCCM aggregate data, not CHIP specific data, is available from the enrollment broker database Progress Summary: Survey respondents and focus group participants reported a high degree of satisfaction with their benefits package and the quality of health care provided by providers Narrative Detail: The Department of Human Services contracted with the Muskie School of Public Service to conduct 2 CHIP enrollee telephone surveys. The 1st survey was done in January /February 1999. The 2nd survey was done in November

Table 1.3		
		1999. In the 1st survey, participants were asked about how easy it was to get services and their overall satisfaction with their coverage. Eighty-nine % of the respondents reported that it was either very or somewhat easy to access services and 86% reported that they were either very or somewhat satisfied with the program. In the 2nd survey, participants were asked how they were treated by their providers, if providers explained things adequately to them, and to rate their primary care providers. Ninety-five % of the respondents reported that they were treated with courtesy and respect, 90% reported that providers explained things in a way they could understand, and 96% rated their primary care provider as either excellent, very good, or good. There was little variation among respondents in MCO, PCCM, or FFS. The Department contracted with Warren Marketing Group to conduct participant focus groups in November/December 1999 and February 2000. Participants consistently rated the coverage and their providers between 8-10 on a scale of 1 (worst) to 10 (best). MCO data about complaints/grievances is not available. PCCM data is available only in the aggregate for all participant groups and not specifically for CHIP. However, the PCCM data for February 2000 indicates that 94% of the complaints have to do with billing problems not access to or quality of care. Historically, billing complaints have been the majority of complaints received.

SECTION 2. BACKGROUND

This section is designed to provide background information on CHIP program(s) funded through Title XXI.

2.1 How are Title XXI funds being used in your State?

2.1.1 List all programs in your State that are funded through Title XXI. (Check all that apply.)

X Providing expanded eligibility under the State's Medicaid plan (Medicaid CHIP expansion)

Name of program: Medicaid Expansion

Date enrollment began (i.e., when children first became eligible to receive services): July 1, 1998

X Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (State-designed CHIP program)

Name of program: Cub Care

Date enrollment began (i.e., when children first became eligible to receive services): August 1, 1998

___ Other - Family Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other - Employer-sponsored Insurance Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other - Wraparound Benefit Package

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other (specify) _____

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

2.1.2 **If State offers family coverage:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

NA

2.1.3 **If State has a buy-in program for employer-sponsored insurance:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

NA

2.2 What environmental factors in your State affect your CHIP program? (Section 2108(b)(1)(E))

2.2.1 How did pre-existing programs (including Medicaid) affect the design of your CHIP program(s)?

The Department of Human Services did not want to create another "system" for the CHIP. Both the Medicaid Expansion and Cub Care programs are Medicaid "look alike" programs. Both programs provide the same benefits as the Medicaid program and use the same delivery systems, provider networks, and administrative structures.

2.2.2 Were any of the preexisting programs "State-only" and if so what has happened to that program?

X No pre-existing programs were "State-only"

___ One or more pre-existing programs were "State only" ! Describe current status of program(s): Is it still enrolling children? What is its target group? Was it folded into CHIP?

2.2.3 Describe changes and trends in the State since implementation of your Title XXI program that "affect the provision of accessible, affordable, quality health insurance and healthcare for children." (Section 2108(b)(1)(E))

Examples are listed below. Check all that apply and provide descriptive narrative if applicable. Please indicate source of information (e.g., news account, evaluation study) and, where available, provide quantitative measures about the effects on your CHIP program.

X Changes to the Medicaid program

___ Presumptive eligibility for children
___ Coverage of Supplemental Security Income (SSI) children
X Provision of continuous coverage (specify number of months 6)
Effective October 1999
___ Elimination of assets tests
___ Elimination of face-to-face eligibility interviews
___ Easing of documentation requirements

___ Impact of welfare reform on Medicaid enrollment and changes to AFDC/TANF (specify)_____

X Changes in the private insurance market that could affect affordability of or accessibility to private health insurance

X Health insurance premium rate increases
Bureau of Insurance data indicates that individual health market rates have increased 40% -109% since January 1, 1998. Based on anecdotal information received by the Bureau of Insurance, they believe that there also has been a double digit increase in the group market rates.
___ Legal or regulatory changes related to insurance
X Changes in insurance carrier participation (e.g., new carriers entering market or existing carriers exiting market)
According to the Bureau of Insurance, (1) as of February 2 ,2000, Tufts of New England is no longer operational in the State, and (2) as of

January 4, 2000, Harvard Pilgrim Health Care is in receivership and is not accepting new business.

___ Changes in employee cost-sharing for insurance

___ Availability of subsidies for adult coverage

___ Other (specify) _____

X Changes in the delivery system

X Changes in extent of managed care penetration (e.g., changes in HMO, IPA, PPO activity)
See above re: Tufts of New England and Harvard Pilgrim Health Care

___ Changes in hospital marketplace (e.g., closure, conversion, merger)

___ Other (specify) _____

___ Development of new health care programs or services for targeted low-income children (specify) _____

___ Changes in the demographic or socioeconomic context

___ Changes in population characteristics, such as racial/ethnic mix or immigrant status (specify) _____

___ Changes in economic circumstances, such as unemployment rate (specify) _____

___ Other (specify) _____

___ Other (specify) _____

SECTION 3. PROGRAM DESIGN

This section is designed to provide a description of the elements of your State Plan, including eligibility, benefits, delivery system, cost-sharing, outreach, coordination with other programs, and anti-crowd-out provisions.

3.1 Who is eligible?

3.1.1 Describe the standards used to determine eligibility of targeted low-income children for child health assistance under the plan. For each standard, describe the criteria used to apply the standard. If not applicable, enter "NA."

Table 3.1.1

	Medicaid CHIP Expansion Program	**State-designed CHIP Program**	**Other CHIP Program*** _____
Geographic area served by the plan (Section 2108(b)(1)(B)(iv))	Statewide	Statewide	
Age	Age 1 through age 18	Age 1 through age 18	
Income (define countable income)	125.1%/133.1% - 150% Count all non-excluded income minus $90 work disregard and child care disregards of up $200 per month for each child under age 2 and $175 per month for each child 2 years and over. Attachment 1 is excluded income policy.	150.1% - 200% Count all non-excluded income. Attachment 1 is excluded income policy.	
Resources (including any standards relating to spend downs and disposition of resources)	NA	NA	

Residency requirements	Maine resident – no durational requirement	Maine resident – no durational requirement	
Disability status	NA	NA	
Access to or coverage under other health coverage (Section 2108(b)(1)(B)(i))	U2 children must be uninsured. There is a 3 month waiting period when a child loses health insurance provided by an employer unless: the family pays 50% or more of the cost of the child's coverage; or the family pays over 10% of all income for family coverage; or the child lost coverage for a reason other than to get coverage, e.g. loss of employment.	Must be uninsured. See explanation about U2 children.	
Other standards (identify and describe)			

3.1.2 How often is eligibility redetermined?

Table 3.1.2			
Redetermination	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Monthly			
Every six months	X	X	
Every twelve months			
Other (specify)			

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.1.3 Is eligibility guaranteed for a specified period of time regardless of income changes? (Section 2108(b)(1)(B)(v))

__X__ Yes ° Which program(s)? __Medicaid Expansion and Cub Care__

For how long? __6 months__

___ No

3.1.4 Does the CHIP program provide retroactive eligibility?

__X__ Yes ° Which program(s)? __Only for Medicaid Expansion; not for Cub Care__

How many months look-back? __3 months__

___ No

3.1.5 Does the CHIP program have presumptive eligibility?

__X__ Yes ° Which program(s)? __Medicaid Expansion and Cub Care__

Which populations? __Pregnant women__

Who determines? __Rural Health Centers, Federally Qualified Health Centers, and Family Planning Agencies__

___ No

3.1.6 Do your Medicaid program and CHIP program have a joint application?

__X__ Yes ° Is the joint application used to determine eligibility for other State programs? If yes, specify:
The Department has 2 applications: a 1 page application for Medicaid and Cub Care only and a 6 page application for Medicaid, Cub Care, Food Stamps, and TANF.

___ No

3.1.7 Evaluate the strengths and weaknesses of your *eligibility determination* process in increasing creditable health coverage among targeted low-income children.

Strengths: short/simplified application (1 page); application by mail; interviews not required unless application incomplete; minimum documentation required; 16 regional offices where information/application assistance available; toll-free helpline available for information and application assistance; health benefits advisor available for those enrolling in MCO or PCCM.
Weaknesses: limited interaction between staff and applicants/recipients because applications mailed; process/system for ensuring that applicants are mailed handbook explaining coverage and other policies.

3.1.8 Evaluate the strengths and weaknesses of your *eligibility redetermination* process in increasing creditable health coverage among targeted low-income children. How does the redetermination process differ from the initial eligibility determination process?

Individuals are determined eligible for a 6 month period. In the 5th month of the 6 month eligibility period, households are sent a redetermination form in the mail with a postage paid envelope for returning the form. If the form is not returned, the case is denied/closed. The strengths and weaknesses are the same as identified in 3.1.7. In addition, want to develop capability to pre-print basic information on the redetermination form.

3.2 What benefits do children receive and how is the delivery system structured? (Section 2108(b)(1)(B)(vi))

3.2.1 Benefits

Please complete Table 3.2.1 for each of your CHIP programs, showing which benefits are covered, the extent of cost sharing (if any), and benefit limits (if any).

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose "select"

"table." Once the table is highlighted, copy it by selecting "copy" in the Edit menu and then "paste" it under the first table.

Table 3.2.1 CHIP Program Type Medicaid Expansion and Cub Care. Medicaid benefit package provided to Medicaid Expansion and Cub Care participants.			
Benefit	Is Service Covered? (**T** = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Inpatient hospital services	X		
Emergency hospital services	X		
Outpatient hospital services	X		
Physician services	X		No cosmetic, experimental, investigational
Clinic services	X		
Prescription drugs	X		FDA approved or indicated only
Over-the-counter medications	X		Prior authorization required for some; most not covered
Outpatient laboratory and radiology services	X		Physician ordered
Prenatal care	X		
Family planning services	X		
Inpatient mental health services	X		
Outpatient mental health services	X		
Inpatient substance abuse treatment services	X		
Residential substance abuse treatment services	X		
Outpatient substance abuse treatment services	X		3 hours per week
Durable medical equipment	X		Prior authorization required for many pieces of equipment
Disposable medical supplies	X		

Preventive dental services	X		
Restorative dental services	X		Prior authorization required for orthodontia
Hearing screening	X		If audiology evaluation performed within the last 4 months, prior authorization is required.
Hearing aids	X		Under age 21; prior authorization required
Vision screening	X		Prior authorization required for some services like low vision aids
Corrective lenses (including eyeglasses)	X		Over 2 pair per year requires prior authorization
Developmental assessment	X		2 developmental & behavioral evaluations per year through the Developmental and Behavioral Evaluation Clinics
Immunizations	X		
Well-baby visits	X		
Well-child visits	X		
Physical therapy	X		2 hours per day
Speech therapy	X		
Occupational therapy	X		2 hours per day
Rehabilitative services	X		
Podiatric services	X		Routine foot care not covered
Chiropractic services	X		Only x-rays for diagnosis and treatment of subluxation and manual manipulation of the spine with diagnosis of subluxation
Medical transportation	X		
Home health services	X		62 day classification; homebound criteria

Nursing facility	X		Prior authorization required
ICF/MR	X		
Hospice care			
Private duty nursing	X		Requires medical assessment
Personal care services	X		Requires medical assessment
Habilitative services	X		
Case management/Care coordination	X		
Non-emergency transportation	X		For medical appointments for covered health services
Interpreter services	X		
Other: Certified Family & Pediatric Nurse Practitioners	X		
Other: Licensed Clinical Social Worker & Licensed Clinical Professional Counselor Services	X		Prior authorization required

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose "select" "table." Once the table is highlighted, copy it by selecting "copy" in the Edit menu and then "paste" it under the first table.

3.2.2 Scope and Range of Health Benefits (Section 2108(b)(1)(B)(ii))

Please comment on the scope and range of health coverage provided, including the types of benefits provided and cost-sharing requirements. Please highlight the level of preventive services offered and services available to children with special health care needs. Also, describe any enabling services offered to CHIP enrollees. (Enabling services include non-emergency transportation, interpretation, individual needs assessment, home visits, community outreach, translation of written materials, and other services designed to facilitate access to care.)

Medicaid Expansion and Cub Care are Medicaid "look alike" programs and thus CHIP participants, including children with special health needs, receive the same benefit package as Medicaid participants. The benefit package is comprehensive and provides access to all preventive services including EPSDT. There are no cost sharing requirements except for premiums paid by Cub Care participants. Premiums range from $5 - $30 per month depending on family size and income. Enabling services provided to facilitate access to services include: non-emergency transportation to appointments for covered services; translation of written materials; interpretation; toll-free helpline to provide information and application assistance; and a health benefits advisor for those participating in managed care.

3.2.3 Delivery System

Identify in Table 3.2.3 the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Check all that apply.

There are 3 delivery systems: MCO, PCCM, and FFS.
MCO: The Department of Human Services has a contract with 1 MCO. The MCO operates in 7 of the 16 counties. CHIP participants may enroll in the MCO on a voluntary basis. The Department expects to transition to mandatory enrollment within the next 12 –18 months .
PCCM: PCCM is operational in 9 counties and expects to be operational statewide by December 2000.
FFS: For those who are not managed care eligible or for carved out services.

Table 3.2.3

Type of delivery system	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
A. Comprehensive risk managed care organizations (MCOs)	Yes	Yes	
Statewide?	___ Yes X No	___ Yes X No	___ Yes ___ No
Mandatory enrollment?	___ Yes X No	___ Yes X No	___ Yes ___ No
Number of MCOs	1	1	
B. Primary care case management (PCCM) program	Yes	Yes	
C. Non-comprehensive risk contractors for selected services such as mental health, dental, or vision (specify services that are carved out to managed care, if applicable)	No	No	

D. Indemnity/fee-for-service (specify services that are carved out to FFS, if applicable)	Attachment 2 is the list of MCO/PCCM services carved out to FFS.	Attachment 2 is the list of MCO/PCCM services carved out to FFS	
E. Other (specify)			
F. Other (specify)			
G. Other (specify)			

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.3 How much does CHIP cost families?

3.3.1 Is cost sharing imposed on any of the families covered under the plan? (Cost sharing includes premiums, enrollment fees, deductibles, coinsurance/ copayments, or other out-of-pocket expenses paid by the family.)

___ No, skip to section 3.4

_X_ Yes, check all that apply in Table 3.3.1

Table 3.3.1			
Type of cost-sharing	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*_____ _____ _
Premiums	NA	X	
Enrollment fee	NA	NA	
Deductibles	NA	NA	
Coinsurance/copayments**	NA	NA	
Other (specify) _____			

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

**See Table 3.2.1 for detailed information.

3.3.2 **If premiums are charged:** What is the level of premiums and how do they vary by program, income, family size, or other criteria? (Describe criteria and attach schedule.) How often are premiums collected? What do you do if families fail to pay the premium? Is there a waiting period (lock-out) before a family can re-enroll? Do you have any innovative approaches to premium collection?

Cub Care participants are required to pay a premium based on family income and size. See chart below.

Family Income As % Of Federal Poverty Level	Monthly Premium For 1 Child	Monthly Premium For 2 or More Children
150.1% - 160%	$ 5	$10
160.1% - 170%	$10	$20
170.1% - 200%*	$15	$30

*200% Effective 10/1/99

Premiums are due on the 1st day of each month for coverage for that month. When a premium is not paid by the 1st of the month in which it is due, the Department will give notice of non-payment. There is a grace period for non-payment of premiums. For the 1st through the 5th month of the 6 month enrollment period, the grace period extends through the last day of the 6 month enrollment period. The grace period for payment of the premium due in the 6th month is the 15th of month 7. There is a month of ineligibility for each month a premium was due, coverage was received, and a premium was not made. The maximum period of ineligibility is 3 months. The penalty period starts in the 1st month following the end of the enrollment period in which the premium was due. No penalty is imposed if premiums are not paid and the Department determines that good cause exists, e.g., mail delay.

Participants are sent a premium coupon for each month a premium is due or overdue. Premiums payments are sent to a central payment center. Premium coupons seem to be easily used.

3.3.3 **If premiums are charged:** Who may pay for the premium? Check all that apply. (Section 2108(b)(1)(B)(iii))

X Employer

_X_ Family
_X_ Absent parent
_X_ Private donations/sponsorship
_X_ Other (specify) Any 3rd party

Note: Premium coupons are sent to the recipient and s/he is ultimately responsible for making sure the premiums are paid.

3.3.4 **If enrollment fee is charged:** What is the amount of the enrollment fee and how does it vary by program, income, family size, or other criteria?

NA

3.3.5 **If deductibles are charged:** What is the amount of deductibles (specify, including variations by program, health plan, type of service, and other criteria)?

NA

3.3.6 How are families notified of their cost-sharing requirements under CHIP, including the 5 percent cap?

The only cost-sharing requirement are premium payments by Cub Care participants. The premiums are set so that the total premium payment by any family will never exceed the 5% cap. See 3.3.2 for premium amounts.

3.3.7 How is your CHIP program monitoring that annual aggregate cost-sharing does not exceed 5 percent of family income? Check all that apply below and include a narrative providing further details on the approach.

NA – See answer for 3.3.6

___ Shoebox method (families save records documenting cumulative level of cost sharing)
___ Health plan administration (health plans track cumulative level of cost sharing)
___ Audit and reconciliation (State performs audit of utilization and cost sharing)
___ Other (specify)_____

3.3.8 What percent of families hit the 5 percent cap since your CHIP program was implemented? (If more than one CHIP program with cost sharing, specify for each program.)

None – See answer for 3.3.6.

3.3.9 Has your State undertaken any assessment of the effects of premiums on participation or the effects of cost sharing on utilization, and if so, what have you found?

The Department of Human Services contracted with the Muskie School of Public Service at the University of Southern Maine to conduct two telephone surveys of CHIP participants. The first survey was done in January and February of 1999. The second survey was conducted in November of 1999. In both surveys, Cub Care participants were asked "How easily can you afford paying the premiums on a regular basis?". Participants responded as follows:

Response	January/February 1999	November 1999
Very easy	30%	27%
Somewhat easy	32%	34%
Neither easy or hard	16%	12%
Somewhat hard	17%	20%
Very hard	4%	6%
Unknown	1%	1%

3.4 How do you reach and inform potential enrollees?

3.4.1 What client education and outreach approaches does your CHIP program use?

Please complete Table 3.4.1. Identify all of the client education and outreach approaches used by your CHIP program(s). Specify which approaches are used (**T**=yes) and then rate the effectiveness of each approach on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.1						
Approach	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program* _____	
	T = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)
Billboards						
Brochures/flyers	T	3	T	3		
Direct mail by State/enrollment broker/administrative contractor	T	3	T	3		
Education sessions						
Home visits by State/enrollment broker/administrative contractor	T	3	T	3		
Hotline	T	3	T	3		
Incentives for education/outreach staff						
Incentives for enrollees						
Incentives for insurance agents						
Non-traditional hours for application intake						
Prime-time TV advertisements	T	3	T	3		
Public access cable TV	T	3	T	3		
Public transportation ads						

Developed by the National Academy for State Health Policy

Radio/newspaper/TV advertisement and PSAs	X	3	X	3		
Signs/posters	T	3	T	3		
State/broker initiated phone calls						
Other (specify)						
Other (specify)						

NOTE: Rated all 3s because limited evaluation done. See 3.4.3

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

Please complete Table 3.4.2. Identify all the settings used by your CHIP program(s) for client education and outreach. Specify which settings are used (**T**=yes) and then rate the effectiveness of each setting on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.2						
Setting	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program* _____	
	T = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)
Battered women shelters						
Community sponsored events	T	3	T	3		
Beneficiary's home	T	3	T	3		
Day care centers	T	3	T	3		
Faith communities	T	3	T	3		
Fast food restaurants						
Grocery stores	T	3	T	3		
Homeless shelters	T	3	T	3		
Job training centers	T	3	T	3		
Laundromats						
Libraries	T	3	T	3		
Local/community health centers	T	3	T	3		
Point of service/provider locations	T	3	T	3		
Public meetings/health fairs	T	3	T	3		

Public housing	T	3	T	3		
Refugee resettlement programs						
Schools/adult education sites	T	3	T	3		
Senior centers						
Social service agency	T	3	T	3		
Workplace	T	3	T	3		
Other (specify)						
Other (specify)						

NOTE: Rated all 3s because limited evaluation done. See 3.4.3.

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.4.3 Describe methods and indicators used to assess outreach effectiveness, such as the number of children enrolled relative to the particular target population. Please be as specific and detailed as possible. Attach reports or other documentation where available.

In January/February 1999, the Department contracted with Muskie School of Public Service to conduct a survey of current enrollees. Survey participants were asked where they heard about the program and where they got an application. The greatest number of enrollees, nearly 25%, answered that they heard about CHIP from a "mailing from school". It should be noted that virtually all families with children enrolled in Maine's public and private schools received a brochure distributed by the schools. It thus stands to reason that many enrollees would have heard of CHIP in this manner.

Approximately 40% of the respondents indicated that they heard about CHIP from a source other than those explicitly listed as response options. The most common other source of information named was the Department of Human Services itself. Other responses included: other government and community social services agencies with Head Start and WIC being the most frequently named organizations; newspaper, workplace, legislators, day care providers.

Some respondents found out about CHIP from more than one source. While nearly two-thirds were unable to choose the primary source of information, most of those who did said either school or TV.

More than half of all respondents got their CHIP application from the Department of Human Services, followed by school at approximately 20%.

3.4.4 What communication approaches are being used to reach families of varying ethnic backgrounds?

The 1 page Medicaid/Cub Care application has been translated into 12 languages. A translation card is inserted in the foreign language applications advising applicants to call if they need translation assistance to complete the application. The Department uses the AT&T translation services to communicate with applicants or recipients whose 1st language is not English.

3.4.5 Have any of the outreach activities been more successful in reaching certain populations? Which methods best reached which populations? How have you measured their effectiveness? Please present quantitative findings where available

. See response at 3.4.3.

3.5 What other health programs are available to CHIP eligibles and how do you coordinate with them? (Section 2108(b)(1)(D))

Describe procedures to coordinate among CHIP programs, other health care programs, and non-health care programs. Table 3.5 identifies possible areas of coordination between CHIP and other programs (such as Medicaid, MCH, WIC, School Lunch). Check all areas in which coordination takes place and specify the nature of coordination in narrative text, either on the table or in an attachment.

Table 3.5

Type of coordination	Medicaid*	Maternal and child health	Other (specify) _____	Other (specify) _____
Administration	NA	NA		
Outreach	NA	NA		
Eligibility determination	NA	NA		
Service delivery	NA	NA		
Procurement	NA	NA		
Contracting	NA	NA		
Data collection	NA	NA		
Quality assurance	NA	NA		
Other (specify)				
Other (specify)				

*Note: This column is not applicable for States with a Medicaid CHIP expansion program only.

NOTE: Both the Medicaid Expansion and the Cub Care program are Medicaid "look alike" programs. Both are administered by the Department of Human Services, Bureau of Medical Services, in collaboration with the Bureau of Family Independence (eligibility) and the Bureau of Health (MCH/public health).

3.6 How do you avoid crowd-out of private insurance?

3.6.1 Describe anti-crowd-out policies implemented by your CHIP program. If there are differences across programs, please describe for each program separately. Check all that apply and describe.

X Eligibility determination process:

- X Waiting period without health insurance (specify)
  There is a 3 month waiting period for children who drop employer provided coverage unless they meet one of the exceptions allowed by policy. See Table 3.1.1, access to or coverage under other health insurance.
- X Information on current or previous health insurance gathered on application (specify)
  The application asks 3 insurance related questions: (1) children in household who currently have insurance; (2) children in household who lost health insurance in the last 3 months; (3) children in household who could be added to State employee health insurance.
- X Information verified with employer (specify)
  Only to verify exception. See Table 3.1.1, access to or coverage under other health insurance
- X Records match (specify)
  Eligibility records are matched with Bureau of Medical Services, Third Party Liability, to cross check to see if enrollees have insurance. A list of CHIP enrollees identified as having insurance is sent to eligibility workers to review.
- ___ Other (specify)
- ___ Other (specify)

___ Benefit package design:

- ___ Benefit limits (specify)
- ___ Cost-sharing (specify)
- ___ Other (specify)
- ___ Other (specify)

___ Other policies intended to avoid crowd out (e.g., insurance reform):

- ___ Other (specify)

___ Other (specify) _____

3.6.2 How do you monitor crowd-out? What have you found? Please attach any available reports or other documentation.

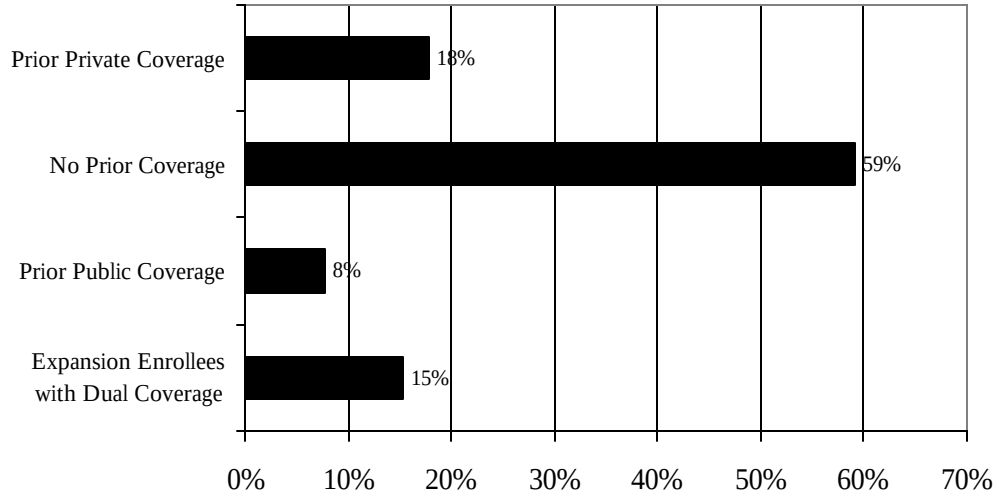
The overall rate of private insurance coverage among children of low-income households has been volatile in recent years due to rapidly rising premium costs and the changes in the insurance market. In December 1999 a random household survey was conducted to determine the rate of privately-insured children from low-income households in Maine. Preliminary survey results (please refer to 1.1.1 regarding limitations of preliminary results) show that from 1997 to 1999 private insurance coverage of children from low-income households (125% - 200% FPL) increased slightly, from 63% to 66%. Likewise, estimated public insurance coverage for children in this income category increased from 15% to 22%. Conversely, the percentage of uninsured children in this income category was reduced from 1997 to 1999 from 21% to 11%. Therefore, our preliminary estimates show no evidence of shifting CHIP-eligible children from private to public insurance coverage.

Children in Households with 125% - 200% FPL Income	**Private Insurance**	**Public Insurance**	**Uninsured**
1997	63.3%	15.3%	21.3%
1999	66.3%	22.4%	11.3%

In November 1999 a survey was conducted of Current Enrollees of the Maine CHIP program. This survey was used as a way to try to measure crowd-out by looking at prior coverage of current program participants. Among the questions asked were the following: did your child have health insurance coverage prior to enrollment in the Medicaid Expansion or the Cub Care program? Was he/she eligible for insurance through an employer? Why is your child no longer participating in the coverage? The results of the survey indicate that 41% of

participants had health insurance for some time in the 12 months prior to enrolling in the CHIP program, 59% did not. Please refer to graph below.

Prior Insurance Coverage of CHIP Enrollees



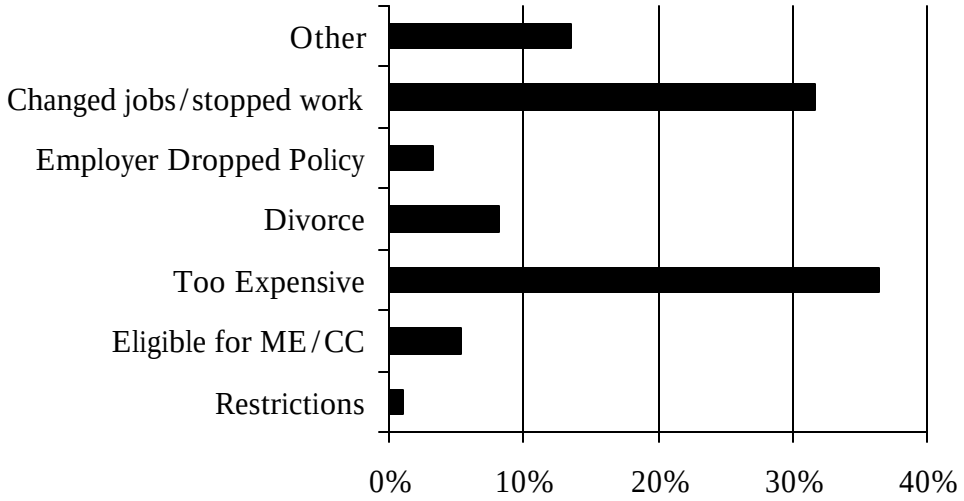
Overall, 18% of participants were covered through private insurers and 8% had prior coverage through public programs. Fifteen percent of enrollees had coverage with a private insurer that was continued after enrollment in the CHIP Medicaid Expansion program. (Note: Certain Medicaid Expansion enrollees may have dual insurance carriers).

The reasons given for discontinuing coverage for the 18% of enrollees with prior private health insurance are shown in the graph below. Thirty-six percent reported that coverage was discontinued because it was too expensive. Thirty-two percent said that the insurance was no longer available because they either stopped work or changed jobs, 8% lost the insurance as a result of a divorce, 5% reported that they had dropped private coverage when they became eligible for the Expansion or the Cub Care program. Of those who have program eligibility as a response, two-thirds became eligible for Medicaid Expansion coverage

and one-third for Cub Care coverage. Three percent reported that the coverage was dropped by an employer. Thirteen percent reported "other" reasons for discontinuing coverage from a private insurer; the reasons specified in this category largely refer to domestic issues including moving residences and spouse separation.

Reasons for Discontinuation of Private Health Insurance

(18% of Enrollees who had private insurance prior to enrollment in CHIP)



Current Eligibility of Employer-Based Coverage

Parents were also asked whether the enrollee was currently eligible for any private health insurance coverage and why they did not participate if eligible. Twenty-four percent of all respondents reported that their child was eligible for an employer-based insurance coverage. However, the majority of these respondents (89%) reported that the insurance cost prohibited participation. The remaining respondents (11%) reported that the insurance did not cover needed services for their child.

There is little variation when looking at the question of current access to employer-based insurance separately for the Medicaid Expansion vs. the Cub Care programs. We find that 27% of Cub Care recipients reported current eligibility from an employer-based insurance. However, 88% of those said that the cost was too high. The remainder reported that needed services were not covered by the employer-based insurance.

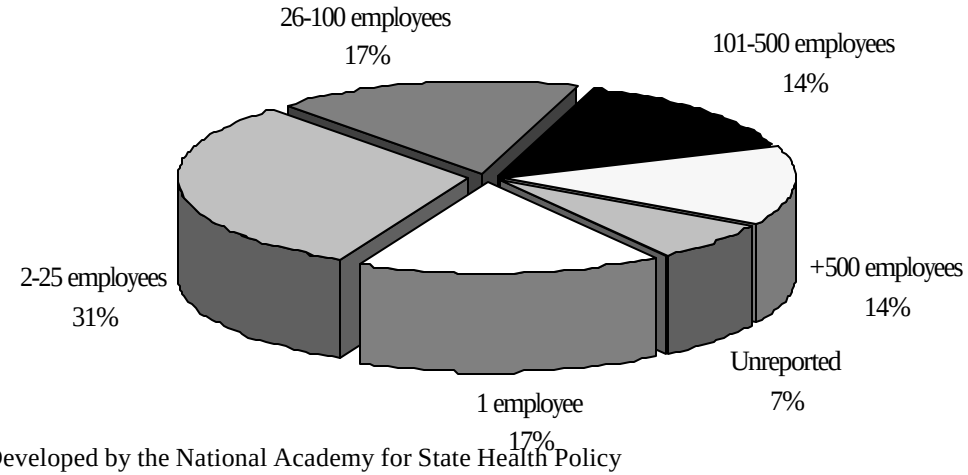
The Medicaid Expansion program allows for dual coverage for certain enrollees and 21% of Medicaid Expansion enrollees currently have another insurance carrier in addition to Medicaid. These enrollees first access their other insurance carrier and, if needed services are not covered, then Medicaid insurance is used. In addition to these 21%, another 17% of Medicaid Expansion enrollees reported that they are currently eligible for employer-based insurance; however, most (93%) reported that the high cost was prohibitive. The remaining 7% indicated that they were waiting for the other insurance to become activated.

Employment Status and Implications on Employer-based Insurance

The likelihood of available and affordable employer-based insurance is related to the firm size with larger firms able to offer family health insurance to their employees at more reasonable rates. Only 14% of CHIP parents who reported full or part-time employment are employed by firms with more than 500 employees. Another 14% are employed by firms with 101-500 employees and the remaining 65% of employed parents or guardians of CHIP enrollees are employed in firms with l00 or fewer employees.

The chart below shows the employer size for those who reported that the primary wage earner in a CHIP family is employed. Note that 76% of CHIP families report full employment. This includes 10% who are self-employed. In addition, 8% had part-time employment and 3% were seasonally employed.

Type of Employment by Size of Business



Summary

There is little evidence to show that the implementation of the CHIP program in Maine has resulted in employers either changing eligibility requirements or dropping coverage for children of employees. The primary reason given by parents for enrollees' lack of participation in employer-based health insurance, when it is available to them is the high cost of health insurance. While it is not possible to determine what proportion of these families would purchase dependent coverage in the absence of the CHIP program, it is probable that many would remain uninsured. This conclusion is supported by the strong skewing of participants toward small businesses and self-employment where group coverage is frequently unavailable and insurance options are very expensive. It is also interesting to note that when parents are able to obtain affordable insurance for their children and still participate in the Medicaid program, as is the case with the 21% of Medicaid Expansion participants, they continue to maintain the additional insurance.

SECTION 4. PROGRAM ASSESSMENT

This section is designed to assess the effectiveness of your CHIP program(s), including enrollment, disenrollment, expenditures, access to care, and quality of care.

4.1 Who enrolled in your CHIP program?

4.1.1 What are the characteristics of children enrolled in your CHIP program? (Section 2108(b)(1)(B)(i))

Please complete Table 4.1.1 for each of your CHIP programs, based on data from your HCFA quarterly enrollment reports. Summarize the number of children enrolled and their characteristics. Also, discuss average length of enrollment (number of months) and how this varies by characteristics of children and families, as well as across programs.

States are also encouraged to provide additional tables on enrollment by other characteristics, including gender, race, ethnicity, parental employment status, parental marital status, urban/rural location, and immigrant status. Use the same format as Table 4.1.1, if possible.

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose "select" "table." Once the table is highlighted, copy it by selecting "copy" in the Edit menu and then "paste" it under the first table.

Table 4.1.1 CHIP Program Type Medicaid Expansion

Characteristics	Number of children ever enrolled		Average number of Months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	2,485	9,871	1.7	5.5	59	3,895
Age						

Under 1*	24	136	1.8	3.5	0	34
1-5	628	2,676	1.7	5.0	18	1,067
6-12	1,133	4,340	1.7	5.6	26	1,628
13-18	700	2,719	1.7	5.8	15	1,166
Countable Income Level*						
At or below 150% FPL	2,485	9,871	1.7	5.5	59	3,895
Above 150% FPL						
Age and Income						
Under 1*						
At or below 150% FPL	24	136	1.8	3.5	0	34
Above 150% FPL						
1-5						
At or below 150% FPL	628	2,676	1.7	5.0	18	1,067
Above 150% FPL						
6-12						
At or below 150% FPL	1,133	4,340	1.7	5.6	26	1,628
Above 150% FPL						

13-18						
At or below 150% FPL	700	2,719	1.7	5.8	15	1,166
Above 150% FPL						
Type of plan						
Fee-for-service	2,171	6,981	1.7	6.0	55	3,162
Managed care	108	755	1.4	4.8	1	201
PCCM	206	2,135	1.6	4.0	3	532

NOTE: CHIP doesn't provide coverage to children under age one; these are reporting/recording anomalies.

Table 4.1.1 CHIP Program Type Cub Care

Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	719	3,786	1.2	5.2	4	1,482
Age						
Under 1*	7	35	1.1	3.6	0	8
1-5	178	1,154	1.2	4.8	2	433
6-12	315	1,543	1.2	5.2	2	575
13-18	219	1,054	1.3	5.6	0	466
Countable Income Level*						

At or below 150% FPL						
Above 150% FPL	719	3,786	1.2	5.2	4	1,482
Age and Income						
Under 1*						
At or below 150% FPL						
Above 150% FPL	7	35	1.1	3.6	0	8
1-5						
At or below 150% FPL						
Above 150% FPL	178	1,154	1.2	4.8	2	433
6-12						
At or below 150% FPL						
Above 150% FPL	315	1,543	1.2	5.2	2	575
13-18						
At or below 150% FPL						
Above 150% FPL	219	1,054	1.3	5.6	0	466
Type of plan						
Fee-for-service	625	2,470	1.3	5.5	4	1,059

Managed care	28	405	1.1	4.8	0	139
PCCM	66	911	1.0	4.4	0	284

NOTE: CHIP doesn't provide coverage to children under age one; these are reporting/recording anomalies.

*Countable Income Level is as defined by the states for those that impose premiums at defined levels other than 150% FPL. See the HCFA Quarterly Report instructions for further details.

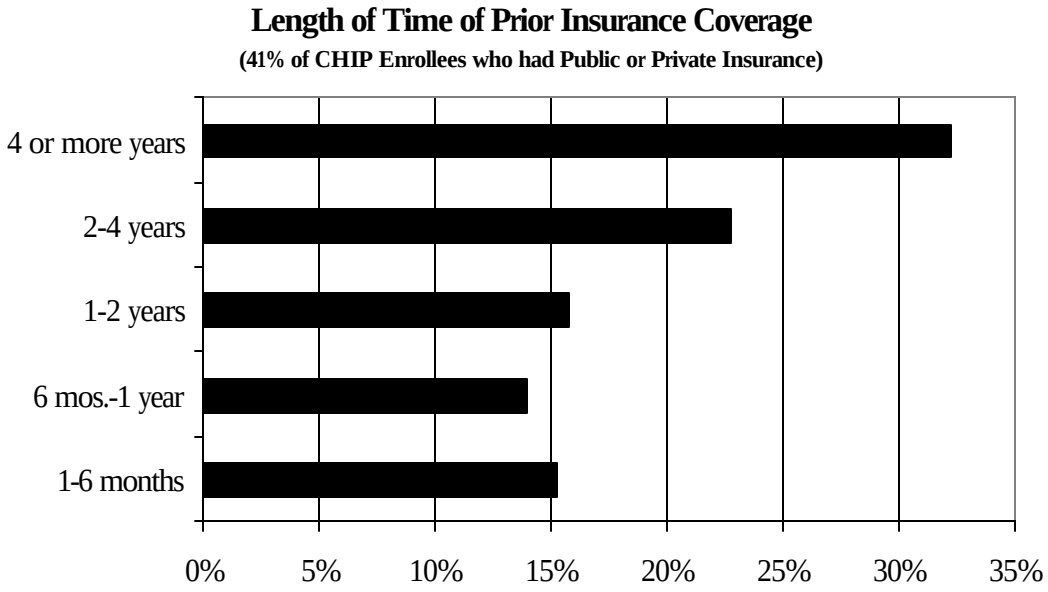
SOURCE: HCFA Quarterly Enrollment Reports, Forms HCFA-21E, HCFA-64.21E, HCFA-64EC, HCFA Statistical Information Management System, October 1998

4.1.2 How many CHIP enrollees had access to or coverage by health insurance prior to enrollment in CHIP? Please indicate the source of these data (e.g., application form, survey). (Section 2108(b)(1)(B)(i))

Case Review
Department of Human Services staff conducted a review of all cases denied (new applications) for the period of September 1998 – June 1999. Thirteen percent of the 495 cases reviewed were denied because the children had insurance.

Current Enrollee Survey
In November 1999, a Current Enrollee Survey was conducted. Survey results regarding availability of prior coverage are discussed in 3.6.2. Further information is provided here regarding the length of time of prior coverage.

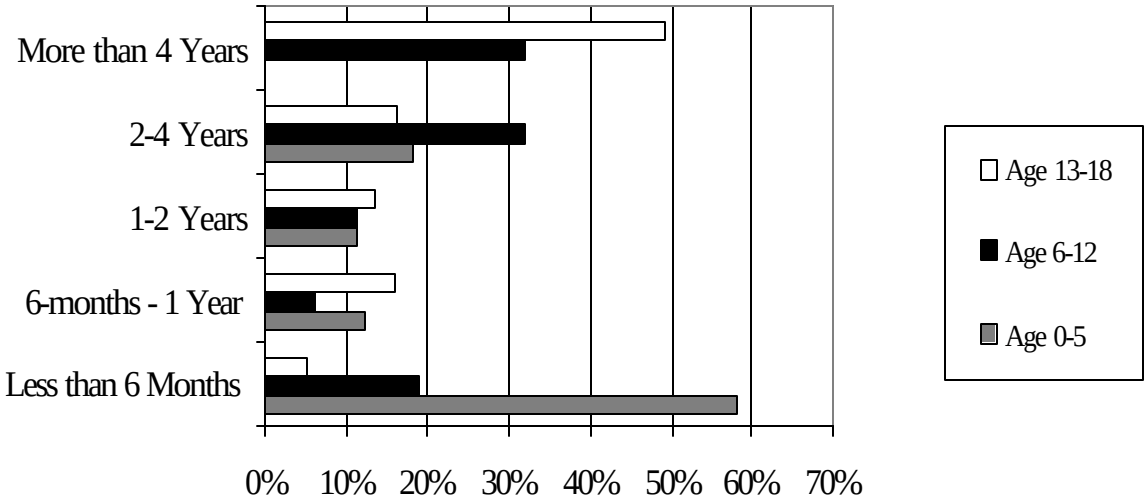
The graph below shows the length of time covered for the 41% of enrollees who reported that they had coverage for some time during the 12 months prior to CHIP enrollment. Thirty-two percent of the enrollees had been covered by some health insurance (public or private) for four or more years, 23% had coverage between two and four years, 16% had coverage between one and two years, 14 % were covered for six months to one year and 15% were covered less than six months.



The following graph illustrates CHIP enrollees' prior private insurance coverage as it relates to the age of the child. These figures represent 18% of CHIP enrollees who had reported that they had private insurance within the 12 months before enrolling in the CHIP program.

Length of Time of Prior Coverage by Child's Age

(18% of CHIP Enrollees who had Private Insurance)



4.1.3 What is the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children? (Section 2108(b)(1)(B)(i))

NA

4.2 Who disenrolled from your CHIP program and why?

4.2.1 How many children disenrolled from your CHIP program(s)? Please discuss disenrollment rates presented in Table 4.1.1. Was disenrollment higher or lower than expected? How do CHIP disenrollment rates compare to traditional Medicaid disenrollment rates?

Data regarding the number of children who disenrolled sometime in the 6 month eligibility period is not available.

4.2.2. How many children did not re-enroll at renewal?

Department of Human Services, Bureau of Family Independence, Enrollment Reports

An analysis of preliminary data available regarding the monthly re-enrollment rates for Cub Care children for the period of July 1999 – December 1999 indicates the following:

- The monthly re-enrollment rates range from 66% - 77%. This represents children whose 6 month eligibility period ended

and whose coverage continued either through Cub Care or Medicaid. Coverage may have been continuous with no break between the old and new 6 month eligibility periods or coverage may have started again after a break between the old and new 6 month eligibility periods.

- Of the children whose coverage continued, between 17% - 26% moved to Medicaid or Medicaid Expansion.

How many of the children who did not re-enroll got other coverage when they left CHIP?

The Department conducted a telephone survey of all households with Cub Care children whose 6 month eligibility period ended in April, May, or June 1999 and who, according to Department records, had not reapplied at the time of the survey.

The Department was able to contact 51% of the households. Of the households contacted, 67% had not reapplied. Reasons stated for not reapplying included:
32% got job/increased income; 18% got private insurance; and 33% other. Other responses included: intend to reapply, didn't think children would qualify; children ineligible due to age.

In November 1999, a Current Enrollee survey was conducted. The Current Enrollee survey found that 53 children (6% of those contacted) reported that they no longer had coverage through Medicaid Expansion or Cub Care at the time they were contacted for the survey. Slightly more of these children had been enrolled in Cub Care rather than Medicaid Expansion and more were from urban areas. The primary reason that children were no longer enrolled, reported by more than half (51%), was that they were no longer eligible due to higher family income. Other reasons given included 21% who reported that their child was recently enrolled in another health insurance plan and 4% who believed CHIP was either too expensive or that they never had used the services. Five percent reported that their child had moved to live with another parent, or on his/her own. The remaining 19% reported problems with paperwork, some of whom indicated that they may be in the process of re-enrolling.

4.2.3 What were the reasons for discontinuation of coverage under CHIP? (Please specify data source, methodologies, and reporting period.)

Data to complete this table is not available at this time.

Table 4.2.3

Reason for discontinuation of coverage	Medicaid CHIP Expansion Program		State-designed CHIP Program		Other CHIP Program* _____	
	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total
Total						
Access to commercial insurance						
Eligible for Medicaid						
Income too high						
Aged out of program						
Moved/died						
Nonpayment of premium						
Incomplete documentation						
Did not reply/unable to contact						
Other (specify)						

Other (specify)						
Don't know						

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.2.4 What steps is your State taking to ensure that children who disenroll, but are still eligible, re-enroll?

The Department of Human Services is working in partnership with the Robert Wood Johnson Covering Kids Campaign grantee in Maine to identify and assist uninsured children to enroll in Medicaid or CHIP, both those who have never been enrolled and those who have disenrolled. The Covering Kids Campaign has established 6 task forces and 2 geographic coalitions. The task forces are: education, health care insurers and providers, business and labor organizations, social services and municipalities, faith groups and service clubs, and consumers. There is one urban and one rural geographic coalition. Each task force and coalition is responsible for developing an annual workplan identifying the most effective outreach and enrollment strategies for their constituencies. Examples of task force and coalition targeted outreach initiatives include: attendance at kindergarten registrations; communication with school coaches and athletes; implementation of a statewide toll free helpline to provide information and assistance with completing applications; provision of technical training to staff of community based agencies who might be assisting individuals with the application process, e.g. Migrant Education teachers, Head Start Health and Social Coordinators, AFL-CIO Peer Support personnel; and general training on the importance of coverage and the application process, e.g. Maine Association of Non-Profits, Maine Businesses for Social Responsibility, Housing Self-Sufficiency Coordinators, Winslow Town Health Forum, Bay Area Chamber of Commerce, Maine Superintendents Association, Maine School Nurses Association, Bread of Life Ministry.

See 4.2.2 regarding survey of Cub Care households whose eligibility ended but children had not reapplied at the time of the survey.

4.3 How much did you spend on your CHIP program?

4.3.1 What were the total expenditures for your CHIP program in federal fiscal year (FFY) 1998 and 1999?

FFY 1998 84,744

FFY 1999 6,756,220

Please complete Table 4.3.1 for each of your CHIP programs and summarize expenditures by category (total computable expenditures and federal share). What proportion was spent on purchasing private health insurance premiums versus purchasing direct services?

Table 4.3.1 CHIP Program Type **Medicaid Expansion**				
Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures	82,588	5,227,176	62,955	3,997,746
Premiums for private health insurance (net of cost-sharing offsets)*	0	5,348	0	4,090
Fee-for-service expenditures (subtotal)	82,588	5,221,828	62,955	3,993,656
Inpatient hospital services	16,473	877,017	12,557	670,743
Inpatient mental health facility services	0	0	0	0
Nursing care services	0	65	0	50
Physician and surgical services	7,556	339,909	5,760	259,963
Outpatient hospital services	12,741	555,767	9,712	425,051
Outpatient mental health facility services	0	0	0	0
Prescribed drugs	14,585	505,097	11,118	386,297
Dental services	9,292	378,223	7,083	289,264
Vision services	647	52,096	493	39,842
Other practitioners' services	805	90,414	614	69,149

Clinic services	11,176	675,582	8,519	516,686
Therapy and rehabilitation services	52	69,662	40	53,278
Laboratory and radiological services	162	24,691	123	18,885
Durable and disposable medical equipment	101	18,600	77	14,225
Family planning	0	0	0	0
Abortions	0	0	0	0
Screening services	0	0	0	0
Home health	395	30,816	301	23,568
Home and community-based services	0	5,437	0	4,158
Hospice	0	0	0	0
Medical transportation	1,546	67,395	1,179	51,544
Case management	1,796	278,299	1,369	212,843
Other services	5,261	1,252,758	4,010	958,110

Table 4.3.1 CHIP Program Type **Cub Care**				
Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures	- 844	1,529,044	- 643	1,169,415
Premiums for private health insurance (net of cost-sharing offsets)*	- 4,530	- 186,966	-3,453	- 142,991
Fee-for-service expenditures (subtotal)	3,686	1,716,010	2,810	1,312,406
Inpatient hospital services	0	251,267	0	192,168
Inpatient mental health facility services	0	0	0	0
Nursing care services	0	49	0	38
Physician and surgical services	265	140,311	202	107,309
Outpatient hospital services	1,052	241,595	802	184,772
Outpatient mental health facility services	0	0	0	0
Prescribed drugs	1,988	170,550	1,515	140,690
Dental services	0	183,956	0	140,690
Vision services	0	16,773	0	12,828
Other practitioners' services	0	0	0	0
Clinic services	187	170,110	143	130,100

Therapy and rehabilitation services	0	29,111	0	22,264
Laboratory and radiological services	24	11,056	18	8,456
Durable and disposable medical equipment	0	9,494	0	7,262
Family planning	0	0	0	0
Abortions	0	0	0	0
Screening services	0	0	0	0
Home health	0	28,036	0	21,442
Home and community-based services	0	0	0	0
Hospice	0	0	0	0
Medical transportation	0	25,476	0	19,485
Case management	0	67,514	0	51,635
Other services	170	370,712	130	283,520

4.3.2 What were the total expenditures that applied to the 10 percent limit? Please complete Table 4.3.2 and summarize expenditures by category.

What types of activities were funded under the 10 percent cap? Personnel, travel, advertising, outreach.

What role did the 10 percent cap have in program design? NA

Table 4.3.2

Type of expenditure	Medicaid Chip Expansion Program*		State-designed CHIP Program		Other CHIP Program* _____	
	FY 1998	FY 1999	FY 1998	FY 1999	FY 1998	FY 1999
Total computable share	-----	-----	0	506,786		
Outreach	-----	-----	0	188,612		
Administrationfs	-----	-----	0	318,174		
Other_____	-----	-----	0	0		
Federal share	-----	-----	0	387,591		
Outreach	-----	-----	0	144,251		
Administration	-----	-----	0	243,340		
Other __ _____	-----	-----	0	0		

*All administrative expenditures eligible for enhanced match are reported on the Title XXI report and not separated specifically by Medicaid Expansion Program and State-designated Program.

Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.3.3 What were the non-Federal sources of funds spent on your CHIP program (Section 2108(b)(1)(B)(vii))

X State appropriations
___ County/local funds
___ Employer contributions
___ Foundation grants
___ Private donations (such as United Way, sponsorship)
___ Other (specify)

4.4 How are you assuring CHIP enrollees have access to care?

4.4.1 What processes are being used to monitor and evaluate access to care received by CHIP enrollees? Please specify each delivery system used (from question 3.2.3) if approaches vary by the delivery system within each program. For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in a Primary Care Case Management program, specify 'PCCM.'

Table 4.4.1

Approaches to monitoring access	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Appointment audits	MCO	MCO	
PCP/enrollee ratios	PCCM, MCO	PCCM, MCO	
Time/distance standards	PCCM, MCO	PCCM, MCO	
Urgent/routine care access standards	MCO	MCO	
Network capacity reviews (rural providers, safety net providers, specialty mix)	PCCM, MCO	PCCM, MCO	
Complaint/grievance/ Disenrollment reviews	PCCM, FFS, MCO	PCCM, FFS, MCO	
Case file reviews	MCO	MCO	
Beneficiary surveys	PCCM, FFS, MCO	PCCM, FFS, MCO	
Utilization analysis (emergency room use, preventive care use)	PCCM, FFS, MCO	PCCM, FFS, MCO	
Other (specify) _____			
Other (specify) _____			

Other (specify) _____			

*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

4.4.2 What kind of managed care utilization data are you collecting for each of your CHIP programs? If your State has no contracts with health plans, skip to section 4.4.3.

NOTE: In 1998 when CHIP was implemented, the Department envisioned MCOs would be the primary delivery system. The Department issued 2 Request for Proposals seeking MCOs interested in providing services to the Medicad/CHIP population but was able to contract with only 1 MCO. Currently, approximately 2000 Medicaid/CHIP participants are enrolled in the MCO.

Table 4.4.2

Type of utilization data	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Requiring submission of raw encounter data by health plans *	X Yes ___ No	X Yes ___ No	___ Yes ___ No
Requiring submission of aggregate HEDIS data by health plans	X Yes ___ No	X Yes ___ No	___ Yes ___ No
Other (specify) EPSDT **	X Yes ___ No	X Yes ___ No	___ Yes ___ No

* Encounter data submitted weekly; complete HCFA 1500 and UB 92 claims data required; reviewing whether need complete claims data

** Complete all EPSDT data in accordance with HCFA 416. Data submitted quarterly.

Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.4.3 What information (if any) is currently available on access to care by CHIP enrollees in your State? Please summarize the results.

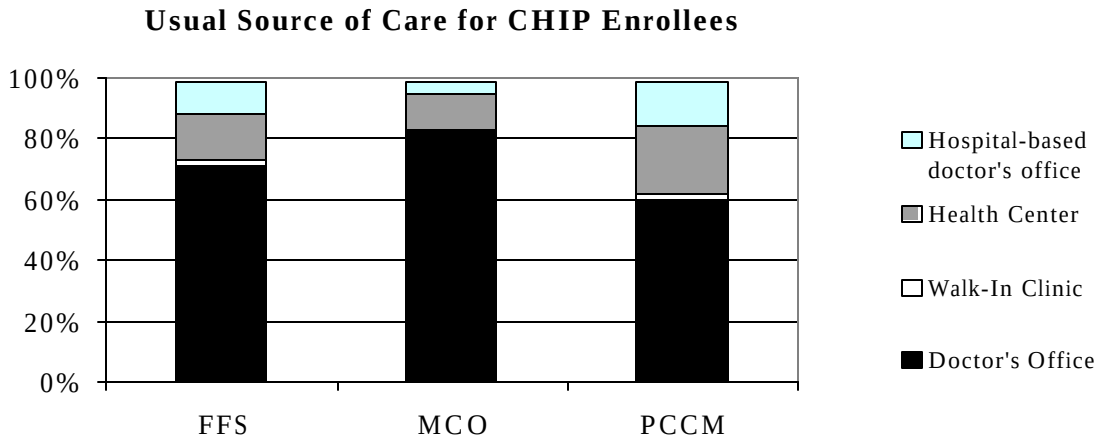
A. Current Enrollee Survey

The Current Enrollee survey conducted in November 1999 asked parents of children enrolled in both Medicaid Expansion and Cub Care questions regarding access to routine health care, including the likelihood of seeing the same provider, access to health care information via the phone, and use of emergency rooms. The results were examined by the delivery mode and by program type to determine whether there are differences in access to care among CHIP enrollees. Please note that the survey

results represent 70% Medicaid Expansion and 30% Cub Care enrollees who had received care in the following delivery modes for at least six months: 80% FFS, 5% MCO and 15% PCCM. This distribution in the survey sample is reflective of the distribution of program participants at the time the survey was conducted. Due to the small numbers of the MCO and PCCM participants in the sample, variations within these delivery modes are not statistically significant.

Source for Routine Care

Parents of enrollees were asked where their children received their routine health care, whether it was in a doctor's office, hospital-based doctor's office, one of Maine's network of Federally Qualified Health Clinics(FQHC)/Rural Health Centers, a hospital emergency room or other place. The majority of enrollees reported receiving health care in a doctor's office, either individual or hospital-based. No enrollees reported receiving usual or routine care in a hospital emergency room. The following graph indicates where beneficiaries, in each delivery model, receive health care services.



Seventy-one percent of FFS Chip enrollees receive their routine health care in a doctor's office, 15% receive care in a FQHC/Rural Health Center, and 11% receive care in their doctor's office located in a hospital. Two percent reported their care was received at a Walk-in clinic.

The largest number of enrollees obtaining routine health care at a doctor's office, 82%, are MCO clients. Twelve percent of those enrolled in an MCO receive health care at a FQHC/Rural Health Center, 4% receive care in a hospital-based doctor's office and the remaining 1% go to Walk-in clinics.

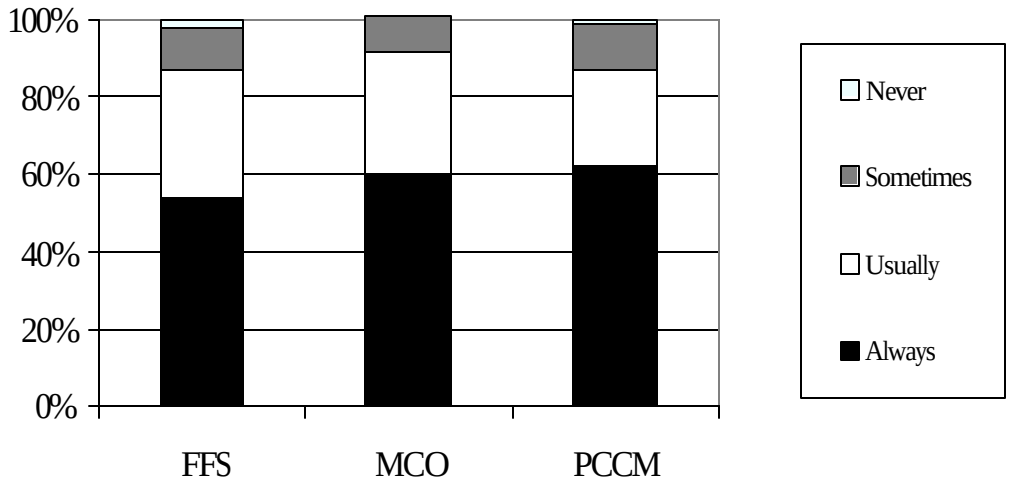
PCCM clients receive their care primarily at a doctor's office, 60%. Twenty-two percent receive care at a FQHC/Rural Health Center, 15% at a hospital-based doctor's office and 2% receive care at a Walk-in clinic.

Enrollees who receive care at Walk-in clinics are primarily from two towns, one where there is a university which has a walk-in health clinic, and the other which has a shortage of physicians and many practices are closed to new clients.

Beneficiaries Seen by Same Provider

Eighty-seven percent of all respondents reported that their children always or usually saw the same provider when they received care. This amount was uniform across delivery models as seen in the graph below.

How Often CHIP Enrollees See the Same Provider



Health Information via Phone

Parents of enrollees were asked if they had sought health care advice over the phone during the previous six months and whether it was a big or small problem. Thirty-five percent had tried to receive advice on health care via the phone. Of those, 5% reported that it was a big problem; 17% reported that accessing health care on the phone was a small problem. Both groups were asked the nature of the problem; the primary reason reported was that the provider took too long to call back, 49%. Twelve percent reported that the provider never called back and 23% reported "Other". Most responses in the "Other" category indicated that the provider instructed the beneficiary to come into the provider's office or clinic to be seen.

Use of Emergency Rooms

Use of the Emergency Room for routine care is an indication that participants do not have access to regular primary care providers for health care. No CHIP parents reported that their children used the Emergency Room for routine care. Nineteen percent of parents who participated in the survey reported that their child had visited an emergency room for care in the previous six months. When asked the reason, 57% reported a life-threatening condition or an accident, 27% reported a chronic illness emergency or a minor illness, 9% reported that they had either been instructed to go there or that their usual source of care was closed. The remaining 8% reported "Other" reasons.

B. PCP/Enrollee Ratios

The PCCM program goal is to have a network of PCPs representing a ratio of 100:1. Of the 10 counties where PCCM is operational or where recruiting is underway, 9 or them are at or below the target ratio of 100:1.

C. Time/Distance Standards

The PCCM program computerized data system has an internal mapping system that automatically alerts the enrollment broker to PCP choices within a 30 mile radius from the recipient's home. The recipient is made aware of those choices but is allowed to select other PCPs. The vast majority of recipients enroll with a PCP within 30 miles of their home; only a very few recipients elect to enroll with a provider outside of the 30 mile radius.

D. Complaint/Grievance/Disenrollment Reviews

All complaints and grievances for the PCCM program are captured in a database and followed through with by either enrollment broker or State staff having expertise in the resolution of the stated problem. Simple complaints of an administrative

nature are resolved, if possible, during the initial call. For questions requiring clarification, a final response is usually provided within 48 hours. Formal grievances are to be resolved within 5 business days. For the month of February 2000, according the the database information, 94% of the complaints/grievances were related to billing issues. Historically complaints/grievances related to billings issues have represented between 90% -95% of all complaints/grievances received.

4.4.4 What plans does your CHIP program have for future monitoring/evaluation of access to care by CHIP enrollees? When will data be available?

The Department has contracted with the Muskie School of Public Service to conduct a telephone survey of PCCM enrollees. The survey will be in the field from April through July 2000. The survey will inquire about access issues.

4.5 How are you measuring the quality of care received by CHIP enrollees?

4.5.1 What processes are you using to monitor and evaluate quality of care received by CHIP enrollees, particularly with respect to well-baby care, well-child care, and immunizations? Please specify the approaches used to monitor quality within each delivery system (from question 3.2.3). For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in primary care case management, specify 'PCCM.'

Table 4.5.1

Approaches to monitoring quality	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program
Focused studies (specify)FACCT - see 4.5.3	PCCM, FFS, MCO	PCCM, FFS, MCO	
Client satisfaction surveys	PCCM, MCO	PCCM, MCO	
Complaint/grievance/ disenrollment reviews	MCO	MCO	
Sentinel event reviews	PCCM, MCO	PCCM, MCO	
Plan site visits	PCCM, MCO	PCCM, MCO	
Case file reviews	PCCM, MCO	PCCM, MCO	
Independent peer review	PCCM, MCO	PCCM, MCO	
HEDIS performance measurement	PCCM, MCO	PCCM, MCO	
Other performance measurement (specify) Hybrid	PCCM	PCCM	
Other (specify) PC- PIP –see 4.6 A	PCCM, FFS	PCCM-FFS	

Other (specify) Physician Directed Drug Initiative – see 4.6 B	PCCM, FFS	PCCM, FFS	
Other (specify) HMO Oversight (See 4.5.3 E)			

Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

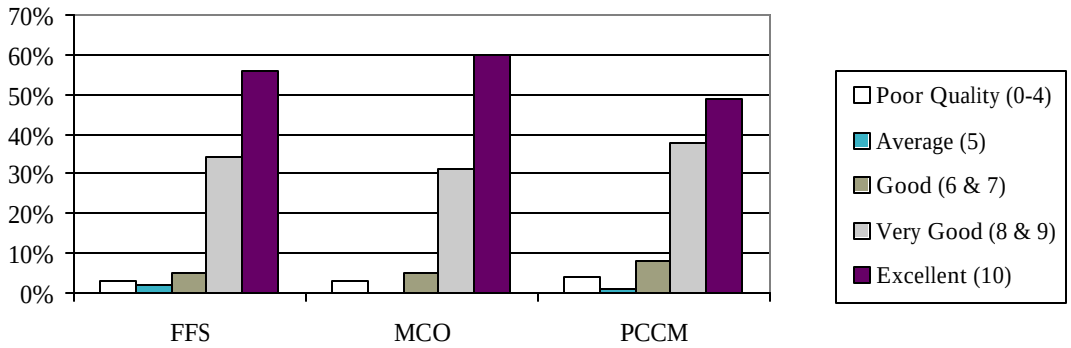
4.5.2 What information (if any) is currently available on quality of care received by CHIP enrollees in your State? Please summarize the results.

The November 1999 Current Enrollee survey included questions regarding the quality of providers and satisfaction indicators relating to quality of care. Please note that the survey results represent 70% Medicaid Expansion and 30% Cub Care enrollees who had received care in the following delivery modes for at least six months: 80% FFS, 5% MCO and 15% PCCM. This distribution in the survey sample is reflective of the distribution of program participants at the time the survey was conducted. Due to the small numbers of the MCO and PCCM participants in the sample, variations within these delivery modes are not statistically significant.

Rating of Primary Care Provider

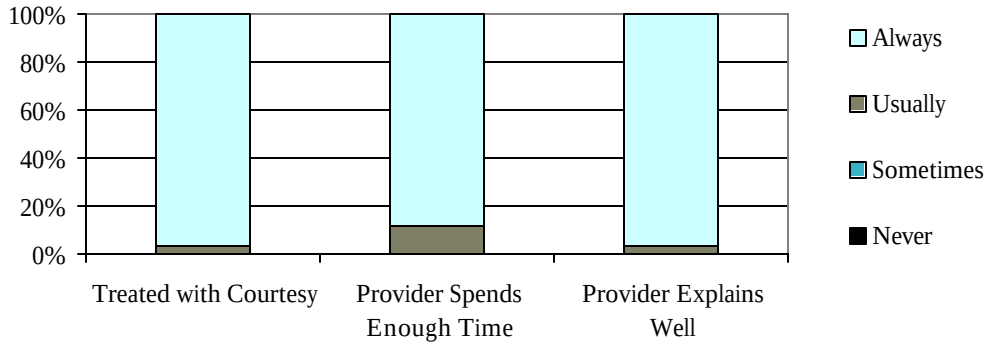
Parents who participated in the Current Enrollee survey were asked to rate the quality of their child's primary care providers on a scale of zero to 10, with zero indicating the poorest provider and 10 indicating the best provider. There was no variation between the Medicaid Expansion and the Cub Care programs; the results by delivery mode, are represented in the graph below. Clients consistently reported their providers to be of high quality; 90% reported their provider to be excellent or very good. Six percent assessed their providers to be of good quality, 2% of average quality and 3% of poor quality.

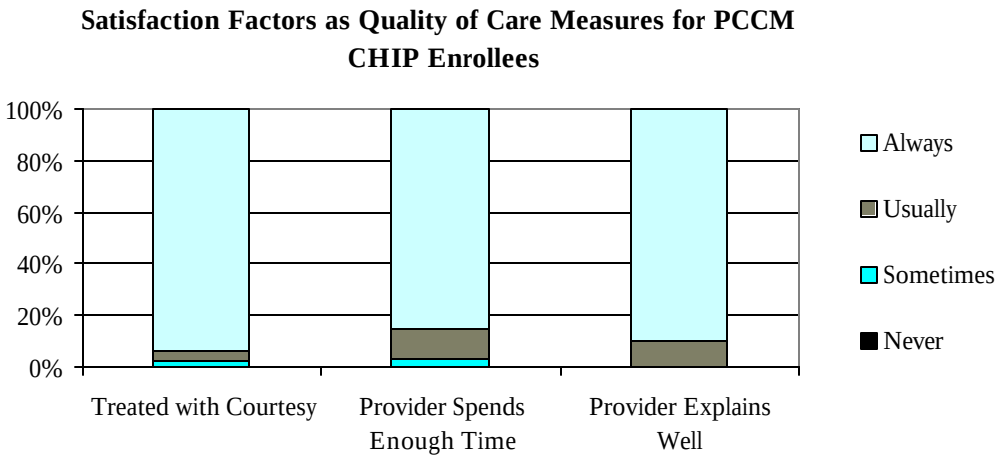
Rating of Quality of Primary Care Provider
(scale of 0-10)



The Current Enrollee survey also used satisfaction with care as a proxy for determining the quality of care received by CHIP enrollees. Parents and guardians were asked if they felt that the provider spent enough time with their child, whether the provider explained things adequately, and whether they were treated with courtesy and respect. There was very little variation between the Medicaid Expansion and the Cub Care programs; the following graphs show the results by delivery program.

Satisfaction Factors as Quality of Care Measures for FFS
Satisfaction Factors as Quality of Care Measures for MCO
CHIP Enrollees





Finally, parents were asked if they had confidence that their child would receive the health care that they needed. Ninety percent reported that they were confident or very confident with the CHIP program. When the remaining 10% who reported less than full confidence were asked the reason for their lack of confidence, they expressed worry that they might not continue to qualify for the CHIP program in the future and that their child would not have health coverage.

4.5.3 What plans does your CHIP program have for future monitoring/evaluation of quality of care received by CHIP enrollees? When will data be available?

A. PCCM Participant Telephone Survey

The Department has contracted with the Muskie School of Public Service to conduct a telephone survey of PCCM enrollees that will be in the field from April through July 2000. The survey will ask enrollees about quality of care.

B. Government Performance and Results Act

The Department is involved as a pilot site in a demonstration project called the Government Performance and Results Act. This project brings together representatives from the Immunization Program and Medicaid/CHIP Programs in each pilot state to improve immunization rates for Medicaid/CHIP children in FFS or PCCM. The Department is in the final stages of developing

the baseline rate comparing record reviews for children on Medicaid/CHIP and those who are covered by other insurers.

C. Foundation for Accountability (FACCT)

The Department is currently conducting a focused study with the Foundation for Accountability to assess what information is provided by the PCP during a child's well child visit. In February 2000, over 3,900 surveys were mailed to families of children, ages 2 months – 4 years of age, who have been enrolled in Medicaid since birth or who have at least 6 months of continuous eligibility. Over 1,300 completed surveys have been returned. Preliminary results are expected to be available in July 2000.

D. Provider Utilization Reports

The Department is in the process of developing Provider Utilization Reports for providers participating in PCCM. These reports will give provider specific utilization information on 19 different areas and compare each provider to those in his/her specialty. The first of these reports are expected to be issued in May 2000.

E. MCO Oversight

The Deparment of Human Services, Bureau of Medical Services (Medicaid Agency) will be providing quality oversight for commercial HMOs in partnership with the Bureau of Insurance. The Department is in the process of finalizing rulemaking to establish standards to ensure that HMOs are implementing and monitoring programs and policies that promote the provision of quality health care. HMOs will be reviewed no less than every 3 years and reviews will be coordinated with the HMOs NCQA review.

4.6 Please attach any reports or other documents addressing access, quality, utilization, costs, satisfaction, or other aspects of your CHIP program's performance. Please list attachments here.

The following are attached:

A. Primary Care Provider Incentive Program (PC-PIP): Listed on Table 4.5.1 as quality measure (Attachment 3)
B. Physician's Directed Drug Initiative: Listed on Table 4.5.1 as quality measure (Attachment 4)
C. PCP Visits – Medicaid and CHIP recipients ages 1-12 with 1 or more visits with a primary care provider (Attachment 5)

D. Average Number of ER Visits per Recipient; Average Avoidable Hospital Conditions per 100 Recipients for Medicaid and CHIP (Attachment 6)
E. Medicaid and CHIP Recipients Who Turned 2 Years of Age and Received Immunizations (Attachment 7)
F. Medicaid and CHIP Recipients Who Turned 15 Months and Received Well Child Visits with a Primary Care Provider; Medicaid and CHIP Recipients Ages 3-6 with One or More Well Child Visits; Medicaid and CHIP Recipients Ages 12-21 with One or More Well Child Visits (Attachment 8)

SECTION 5. REFLECTIONS

This section is designed to identify lessons learned by the State during the early implementation of its CHIP program as well as to discuss ways in which the State plans to improve its CHIP program in the future. The State evaluation should conclude with recommendations of how the Title XXI program could be improved.

5.1 What worked and what didn't work when designing and implementing your CHIP program? What lessons have you learned? What are your "best practices"? Where possible, describe what evaluation efforts have been completed, are underway, or planned to analyze what worked and what didn't work. Be as specific and detailed as possible. (Answer all that apply. Enter 'NA' for not applicable.)

5.1.1 Eligibility Determination/Redetermination and Enrollment

5.1.2 Outreach

5.1.3 Benefit Structure

5.1.4 Cost-Sharing (such as premiums, copayments, compliance with 5% cap)

5.1.5 Delivery System

5.1.6 Coordination with Other Programs (especially private insurance and crowd-out)

5.1.7 Evaluation and Monitoring (including data reporting)

5.1.8 Other (specify)

5.2 What plans does your State have for "improving the availability of health insurance and health care for children"? (Section 2108(b)(1)(F))

On February 1, 2000, Governor Angus King, Jr. appointed the Year 2000 Blue Ribbon Commission on Health Care. The Commission shall evaluate:

- The design and availability of health insurance products;
- Maine's hospital revenue and cost structure;
- The insured population, the uninsured population, and the underinsured population and the demographics and the trends within these groups;
- The impact of current Medicare reimbursement rates on health care;
- The impact of Employment Retirement Income Security Act, Health Insurance Portability and Accountability Act, and other federal regulation on Maine's health care delivery system;
- Collaborative health care purchasing options; and
- Purchasing alternatives for prescription drugs.

The Commission is charged with reporting back to the Governor by November 1, 2000 with its recommendations for stabilizing overall health care costs and identifying different ways to pay for health care.

5.3 What recommendations does your State have for improving the Title XXI program? (Section 2108(b)(1)(G))

- The State recognizes the importance of preventing crowd-out. However, we are concerned that children of public employees are treated differently than other children in this regard. We recommend that state crowd out strategies, such as waiting periods, apply to all children who are applying regardless of the families' source of employment.
- The 10% limit on administrative expenditures is problematic in the first years of a new program when there may be higher costs associated with implementation activities. The Department of Health and Human Services should reconsider the extent of its administrative requirements in relationship to the 10% limit on expenditures.

Addendum to Table 3.1.1

The following questions and tables are designed to assist states in reporting countable income levels for their Medicaid and SCHIP programs and included in the NASHP SCHIP Evaluation Framework (Table 3.1.1). This technical assistance document is intended to help states present this extremely complex information in a structured format.

The questions below ask for countable income levels for your Title XXI programs (Medicaid SCHIP expansion and State-designed SCHIP program), as well as for the Title XIX child poverty-related groups. Please report your eligibility criteria as of **September 30, 1999.** Also, if the rules are the same for each program, we ask that you enter duplicate information in each column to facilitate analysis across states and across programs.

If you have not completed the Medicaid (Title XIX) portion for the following information and have passed it along to Medicaid, please check here and indicate who you passed it along to. Name_____, phone/email_____

3.1.1.1 For each program, do you use a gross income test or a net income test or both?

Title XIX Child Poverty-related Groups ____Gross _X_ Net ____Both

Title XXI Medicaid SCHIP Expansion ____Gross _X_ Net ____Both

Title XXI State-Designed SCHIP Program _X_ Gross ____Net ____Both

Other SCHIP program_____ ____Gross ____Net ____Both

3.1.1.2 What was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately.

Title XIX Child Poverty-related Groups _185_ % of FPL for children under age 12 months

_133_ % of FPL for children aged 1-5

_125_ % of FPL for children aged 6-18

Title XXI Medicaid SCHIP Expansion _150_ % of FPL for children aged 1-18

____% of FPL for children aged _____

____% of FPL for children aged _____

Title XXI State-Designed SCHIP Program _200_ % of FPL for children aged 1-18

____% of FPL for children aged _____

____% of FPL for children aged _____

Other SCHIP program_____ ____% of FPL for children aged _____

____% of FPL for children aged _____

____% of FPL for children aged _____

3.1.1.3 Complete Table 1.1.1.3 to show whose income you count when determining eligibility for each program and which household members are counted when determining eligibility? (In households with multiple family units, refer to unit with applicant child)

Enter "Y" for yes, "N" for no, or "D" if it depends on the individual circumstances of the case.

Table 3.1.1.3

Family Composition	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Child, siblings, and legally responsible adults living in the household	D	D	D	
All relatives living in the household	D	D	D	
All individuals living in the household	N	N	N	
Other (specify)				

3.1.1.4 How do you define countable income? For each type of income please indicate whether it is counted, not counted or not recorded. ***Enter "C" for counted, "NC" for not counted and "NR" for not recorded.***

NOTE: * Partially counted. See Attachment 1 for list of partially excluded and excluded income.

Table 3.1.1.4

Type of Income	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Earnings Earnings of dependent children	C*	C*	C*	
Earnings of students	NC	NC	NC	
Earnings from job placement programs	NC	NC	NC	
Earnings from community service programs under Title I of the National and Community Service Act of 1990 (e.g., Serve America)	C*	C*	C*	
Earnings from volunteer programs under the Domestic Volunteer Service Act of 1973 (e.g., AmeriCorps, Vista)	C*	C*	C*	
Education Related Income Income from college work-study programs	NC	NC	NC	
Assistance from programs administered by the Department of Education	NC	NC	NC	
Education loans and awards	C*	C*	C*	
Other Income Earned income tax credit (EITC)	NC	NC	NC	
Alimony payments received	C	C	C	

Child support payments received	C*	C*	C*	
Roomer/boarder income	C	C	C	
Income from individual development accounts	C*	C*	C*	
Gifts	C*	C*	C*	
In-kind income	C	C	C	
Program Benefits Welfare cash benefits (TANF)	NC	NC	NC	
Supplemental Security Income (SSI) cash benefits	NC	NC	NC	
Social Security cash benefits	C	C	C	
Housing subsidies	NC	NC	NC	
Foster care cash benefits	C*	C*	C*	
Adoption assistance cash benefits	NC	NC	NC	
Veterans benefits	C*	C*	C*	
Emergency or disaster relief benefits	NC	NC	NC	
Low income energy assistance payments	NC	NC	NC	
Native American tribal benefits	NC	NC	NC	
Other Types of Income (specify)				

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.1.1.5 What types and *amounts* of disregards and deductions does each program use to arrive at total countable income?

Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA."

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) __Yes X No

If yes, please report rules for applicants (initial enrollment).

Table 3.1.1.5

Type of Disregard/Deduction	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Earnings	$90	$90	$NA	$
Self-employment expenses	$See Attachment 9	$See Attachment 9	$NA	$
Alimony payments Received	$NA	$NA	$NA	$
Paid	$Total paid	$Total paid	$NA	$
Child support payments Received	$NA	$NA	$NA	$
Paid	$Total paid	$Total paid	$NA	$
Child care expenses	$175/200 depending on age of child	$175/200 depending on child	$NA	$
Medical care expenses	$NA	$NA	$NA	$
Gifts	$NA	$NA	$NA	$

Other types of disregards/deductions (specify)	$	$	$	$

a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "ins
choose "column".

1.6 For each program, do you use an asset or resource test?

Title XIX Poverty-related Groups	_X_ No	____Yes (complete column A in 3.1.1.7)
Title XXI SCHIP Expansion program	_X_ No	____Yes (complete column B in 3.1.1.7)
Title XXI State-Designed SCHIP program	_X_ No	____Yes (complete column C in 3.1.1.7)
Other SCHIP program_____	____No	____Yes (complete column D in 3.1.1.7)

1.7 How do you treat assets/resources?

ase indicate the countable or allowable level for the asset/resource test for each program and describe the disregard for icles. If not applicable, enter "NA."

Table 3.1.1.7 Treatment of Assets/Resources	Title XIX Child Poverty-related Groups (A)	Title XXI Medicaid SCHIP Expansion (B)	Title XX designed Progr (C
Countable or allowable level of asset/resource test	$	$	$
Treatment of vehicles: Are one or more vehicles disregarded? *Yes or No*			
What is the value of the disregard for vehicles?	$	$	$
When the value exceeds the limit, is the child ineligible("I") or is the excess applied ("A") to the threshold allowable amount for other assets? *(Enter I or A)*			

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.1.1.8 Have any of the eligibility rules changed since September 30, 1999? ___ Yes __X__ No